

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



July 28, 1999

ALL COUNTY INFORMATION NOTICE NO. I-47-99

TO: ALL COUNTY WELFARE DIRECTORS
ALL CalWORKs PROGRAM SPECIALISTS
ALL FOOD STAMP PROGRAM COORDINATORS

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☒ Initiated by CDSS

SUBJECT: REVISION OF THE SAWS 2, STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS, AND MEDI-CAL/STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (STATE CMSP); CA 8, STATEMENT OF FACTS FOR AN ADDITIONAL PERSON; AND DFA 285-A2, APPLICATION FOR FOOD STAMPS-PART 2

This letter transmits copies and information regarding the following forms:

- SAWS 2 (7/99) Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/State CMSP
- CA 8 (7/99) Statement of Facts for an Additional Person
- DFA 285-A2 (7/99) Application for Food Stamps-Part 2

These forms are revised to simplify the "CITIZEN/NONCITIZEN" subset item in the applicant information sections on each Statement of Fact and application form. The revisions streamline the choices for each person to: "U.S. Citizen/National" or "Noncitizen." A subset "YES/NO" question asks if the noncitizen is "Sponsored." The county will determine the noncitizen's appropriate category and eligibility status based upon the documentation submitted by the client. The county shall not require an individual to state whether they or anyone in the household is undocumented. Additionally, the header on page 1 on each form is updated to "State of California – Health and Human Services." There are also minor changes on the SAWS 2 and CA 8, which are outlined in Attachment A.

You may also be interested to know that the following Statement of Fact and application forms are currently undergoing a more comprehensive revision:

- SAWS 2 Statement of Facts for Cash Aid, Food Stamps, And Medi-Cal/State CMSP
- CW 8A Statement of Facts To Add A Child Under The Age of 16
- CA 8 Statement of Facts For An Additional Person
- DFA 285-A2 Application for Food Stamps-Part 2

In addition, the SAWS 1, Coversheet and Application for Cash Aid, Food Stamps, and Medi-Cal/State CMSP is being revised.

We expect to release the CW 8A and SAWS 1 within the next few months. The comprehensive revisions of the CA 8 and DFA 285-A2 are expected to be final by the end of the year.

See Attachment A for a copy of pages 1 and 2 of the SAWS 2 (7/99), page 1 of the CA 8 (7/99) and pages 1 and 2 of the DFA 285-A2 (7/99). Attachment A also includes instructions on implementation, how to obtain translations, camera-ready copies, stock, etc.; and it outlines the specific changes to the SAWS 2 and CA 8.

CONTACTS

If you have any questions or need further information, please contact the following staff regarding the specific program areas:

- This letter and the attachments: Jackie Shelley at 654-1061/CALNET 464-1061;
- Food Stamp Program: Bill Shaw at (916) 654-1459/CALNET 464-1459;
- Translations: Shirley LuKung at (916) 654-1277/CALNET 464-1277;
- Medi-Cal: Barbara Rahm at (916) 657-0727/CALNET 437-0727.

Sincerely,
***Original document signed by
Charr Lee Metsker on 7/28/99***
CHARR LEE METSKER, Chief
Employment and Eligibility Branch

Attachments

c: CWDA
 CSAC

Implementation

As soon as the 7/99 versions of the revised SAWS 2 (1/98), CA 8 (4/99), and DFA 285 A2 (7/97) forms are available, counties should begin using the new forms and destroy old stock. The California Department of Social Services (CDSS) Warehouse will no longer stock the previous versions of these forms, and old stock will be destroyed.

Stock

State-produced stock for the 7/99 versions of the SAWS 2, CA 8, and DFA 285-A2 is expected to be available 30 to 45 days after the release of this letter. Stock of the Spanish language versions of each form may be ordered from the CDSS Warehouse according to the forms ordering procedures in the County Forms Catalog upon receipt of the Notice of Change Form (GEN 127), which is issued when stock is available.

Translations and Camera Ready Copies

Translations will be available in approximately 30 days. For Spanish, Chinese, Cambodian, Vietnamese, and Russian versions of the form, counties should call Language Translation Services (LTS) at (916) 657-1282 or CALNET 464-1282. If you need several forms, please fax your request to (916) 657-3429 or e-mail your request to lsu@dss.ca.gov. If your county is on the LTS mailing list, your Forms Coordinator now receives all translations as soon as they become available. Once you have established an e-mail address, please contact the Forms Management Bureau (FMU) by telephone or e-mail at fmud@dss.ca.gov. FMU will then place you on their e-mail list.

For camera-ready copies of the English and Spanish versions of the forms, counties should call FMU at (916) 657-1907 or CALNET at 437-1907. If your office has Internet access, you may obtain various forms and Notice of Form Change (GEN 127) from the CDSS web page at: <http://www.dss.cahwnet.gov>. To accommodate agencies without Internet access, copies will be available by contacting FMU.

Forms Designation and Modification of Forms

The form designation for the SAWS 2 is "Required Form-Substitute Permitted." CWDs must obtain prior approval from the CDSS and/or Department of Health Services (DHS) before implementing a modification or substitution to this and other "Substitute Permitted" forms. For CalWORKs program changes, the procedures for submission of a change request are outlined in Management and Office Procedures Regulations 23-400.22. For proposed Medi-Cal/State CMSP changes to the SAWS 2, CWDs should forward a change request to the DHS, Medi-Cal Eligibility Branch. These modification requirements do not apply to the CA 8, which is designated as "Recommended," and the DFA 285 A-2, which is designated "No Substitutes."

Outline of Formatting Changes

SAWS 2 (7/99), Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/ State CMSP

On page 2, item 3, the subset items "SOCIAL SECURITY NUMBER" and "SEX" are relocated to the space below the "CITIZEN/NONCITIZEN STATUS" section. This provides more space for the "CHILD'S NAME."

CA 8 (7/99), Statement of Facts for An Additional Person

In addition to the change in the "CITIZEN/NONCITIZEN STATUS " section, the name of the form has been slightly modified from "STATEMENT OF FACTS FOR ADDITIONAL PERSON" to "STATEMENT OF FACTS FOR AN ADDITIONAL PERSON."



STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS AND MEDI-CAL/ STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (CMSP)

- Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "FS" for Food Stamps and "MC" for Medi-Cal/State CMSP listed to the left of each question tell you which questions are for each program.
- Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form. If you need more space, attach another sheet.
- If you are asking for Food Stamps and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.

CA FS MC	① A. Name of person applying, or caretaker relative of child(ren) for whom aid is wanted.	HOME PHONE ()
HOME ADDRESS (NUMBER, STREET)		DAYTIME PHONE ()
CITY STATE ZIP CODE		CITY STATE ZIP CODE

FS	B. Are you homeless? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES": Are you temporarily staying in someone else's home? If "YES": List date you began staying at this home: <input type="checkbox"/> YES <input type="checkbox"/> NO
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- ② For each ADULT living in the home, give us all the facts. If you are a non-citizen applying for Medi-Cal and you are not (a) LPR (an alien who is a lawful permanent resident of the U.S.), (b) an amnesty alien with a valid and current I-688, or (c) PRUCOL (an alien permanently residing in the U.S. under color of law), do not fill in the shaded box for "Birthplace."**

CA FS MC	(A) APPLICANT/NAME (FIRST, MIDDLE, LAST)	CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN)		BIRTHDATE / / SOCIAL SECURITY NUMBER — —
SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP		BIRTHPLACE CITY STATE COUNTRY
		MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed

CA FS MC	(B) ADULT'S NAME (FIRST, MIDDLE, LAST)	CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN)		BIRTHDATE / / SOCIAL SECURITY NUMBER — —
SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP		BIRTHPLACE CITY STATE COUNTRY
		MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed

CA FS MC	(C) ADULT'S NAME (FIRST, MIDDLE, LAST)	CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN)		BIRTHDATE / / SOCIAL SECURITY NUMBER — —
SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP		BIRTHPLACE CITY STATE COUNTRY
		MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed

COUNTY USE ONLY

CASE NAME		
CASE NUMBER		
WORKER	DATE RCD	
<input type="checkbox"/> New <input type="checkbox"/> Restoration <input type="checkbox"/> Redetermine <input type="checkbox"/> Recertification <input type="checkbox"/> Residency Verified <input type="checkbox"/> FS ID <input type="checkbox"/> FS Aged/Disabled Verified <input type="checkbox"/> MC ID <input type="checkbox"/> MC Minor Consent: Exempt from ID, Residency, SSN, Verifs		

<input type="checkbox"/> AU	<input type="checkbox"/> NON-AU	<input type="checkbox"/> MFBU
FS Non-HH/Excluded Member Code:		
Work Registration/Exemption Codes:		
WELFARE TO WORK	FS	ABAWDS
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen <input type="checkbox"/> SAVE DATE OF ENTRY IN THE U.S.		

<input type="checkbox"/> AU	<input type="checkbox"/> NON-AU	<input type="checkbox"/> MFBU
FS Non-HH/Excluded Member Code:		
Work Registration/Exemption Codes:		
WELFARE TO WORK	FS	ABAWDS
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen <input type="checkbox"/> SAVE DATE OF ENTRY IN THE U.S.		

<input type="checkbox"/> AU	<input type="checkbox"/> NON-AU	<input type="checkbox"/> MFBU
FS Non-HH/Excluded Member Code:		
Work Registration/Exemption Codes:		
WELFARE TO WORK	FS	ABAWDS
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen <input type="checkbox"/> SAVE DATE OF ENTRY IN THE U.S.		

COUNTY USE ONLY

FS NON-HH/EXCLUDED MEMBER (63-402)	FS WORK/TRAINING EXEMPTIONS (63-407.21)	FS ABAWD EXEMPTIONS (63-410.3)	WORK EXEMPTIONS (42-789 THRU 42-799)
1. Separate HH (Purchase/prepare) (.12, .13) 2. Separate HH (Elderly/disabled) (.17) 3. Roomer (must be listed in 13) (.211) 4. Live-in attendant (.212) 5. Other shared living quarters (.213) 6. Ineligible alien (.221) 7. Boarder (must be listed in 13) (.3) 8. SSN disqualified (.222) 9. IPV disqualified (.223) 10. Workfare sanctioned (.225) 11. SSI/SSP recipient (.226) 12. Ineligible student (.227) 13. Work req. disqualified (.228) 14. Questionable Citizenship (403.31) 15. Vol. quit ineligible (408.1, .2) 16. Ineligible/disqualified ABAWD (410.4) 17. Fleeing felon/parole or probation violator (.224) 18. Drug felon (.229)	a. Under 16/60 or older a.(1) 16/17 not head of household; or 16/17 in school/training at least 1/2 time b. Mentally/physically unfit for work c. Mandatory participant in GAIN or Welfare to Work activities d. Cares for child under 6 or incapacitated person e. Applicant for/recipient of UIB f. Participant in drug/alcohol program g. 30 hour week/min. x 30 h. 1/2 time student in school, training or higher education.	1. ABAWD with FS Work/Training Exemption Code 63-407.21 b, c, d, e, f, or h (.31) 2. Under 18/50 or older (.321) 3. Pregnant (.322) 4. Adult living in HH with dep. child (.323) 5. Lives in ABAWD exempt area (.33)	01 Age under 16 02 School Attendance 03 Disability 04 Age 60 or older 05 Care of Another Individual in household 06 Care of Child 07 Age 6 months or under 08 Pregnancy 09 Nonparent relative caretaker (limited)

COUNTY USE ONLY

CA FS MC (A) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: <input type="checkbox"/> Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD(REN) NEED AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)				AU (✓)	NON-AU (✓)	MFBU (✓)	FS Non-HH/Excluded Member Code	
		SOCIAL SECURITY NUMBER _____		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F		DEATH	DISABILITY	ABSENCE	UNEMPLOYMENT	<input type="checkbox"/> MC: not in home, 18-21 & tax dep.	<input type="checkbox"/> CA 2.1/CA 371	Date of Entry In U.S.
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		BIRTHDATE OR DUE DATE ____ / ____ / ____						BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		Work Registration/Exemption Codes:
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal				MOTHER'S NAME				Welfare-to-Work				FS
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME				Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen				

CA FS MC (B) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: <input type="checkbox"/> Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO				AU (✓)	NON-AU (✓)	MFBU (✓)	FS Non-HH/Excluded Member Code
		SOCIAL SECURITY NUMBER _____ SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> MC: not in home, 18-21 & tax dep.			
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHDATE OR DUE DATE _____ / ____ / ____	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> CA 2.1/CA 371		Date of Entry In U.S. _____	
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal		MOTHER'S NAME _____				Work Registration/Exemption Codes:			
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO	FATHER'S NAME _____				Welfare-to-Work _____ FS _____		
						Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen			

CA FS MC (C) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: <input type="checkbox"/> Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO				AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFBU (✓) <input type="checkbox"/> FS Non-HH/Excluded Member Code	
		SOCIAL SECURITY NUMBER _____ SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		BIRTHDATE OR DUE DATE _____ / _____ / _____		BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE OF AID REQUESTED (✓)		MOTHER'S NAME				<input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None	
<input type="checkbox"/> Medi-Cal						<input type="checkbox"/> CA 2.1/CA 371	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME		Date of Entry In U.S.	
						Work Registration/Exemption Codes:	
						Welfare-to-Work FS	
						Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN	
						<input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet	
						<input type="checkbox"/> SAVE <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen	

CA (D) CHILD'S NAME (FIRST, MIDDLE, LAST) FS MC		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO				AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFBU (✓) <input type="checkbox"/>		FS Non-HH/Excluded Member Code	
		SOCIAL SECURITY NUMBER _ _ _ _ _				SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		BIRTHDATE OR DUE DATE / /		BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> CA 2.1/CA 371	
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal		MOTHER'S NAME						Date of Entry In U.S.	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME				Work Registration/Exemption Codes:	
								Welfare-to-Work FS	
								Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen	

CA (E) CHILD'S NAME (FIRST, MIDDLE, LAST) FS MC		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: <input type="checkbox"/> Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFB (✓) <input type="checkbox"/> FS Non-HH/Excluded Member Code	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHDATE OR DUE DATE / /	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MC: not in home, 18-21 & tax dep. <input type="checkbox"/> CA 2.1/CA 371 Date of Entry In U.S.
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal		MOTHER'S NAME		Work Registration/Exemption Codes:	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO	FATHER'S NAME		Welfare-to-Work FS Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> SAVE <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Non-Citizen

CA MC	4 Does the other parent(s) of the child(ren) or unborn live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain below:						
	<table border="1"> <thead> <tr> <th>NAME OF PARENT</th> <th>GIVE THE REASON THE PARENT DOES NOT LIVE IN THE HOME</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	NAME OF PARENT	GIVE THE REASON THE PARENT DOES NOT LIVE IN THE HOME				
	NAME OF PARENT	GIVE THE REASON THE PARENT DOES NOT LIVE IN THE HOME					

CA 5 FS MC Has anyone changed citizenship/immigration status in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	COUNTY USE ONLY																																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">NAME</td> <td style="width: 25%;">WHAT CHANGED</td> <td style="width: 25%;">DATE</td> <td style="width: 25%;">ALIEN NUMBER (IF APPLICABLE)</td> </tr> </table>	NAME	WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)	<input type="checkbox"/> Verif. on File <input type="checkbox"/> CA 64 <input type="checkbox"/> MC 13																																											
NAME	WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)																																													
CA 6 FS A. Is a foster child living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who:	<input type="checkbox"/> CA and FC Elig/CR Chooses: Child <input type="checkbox"/> CA <input type="checkbox"/> FC CR: <input type="checkbox"/> CA <input type="checkbox"/> None																																															
FS B. Do you want the foster child(ren) and foster care income counted on the Food Stamp Case? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																
CA 7 FS MC Has anyone ever used any other name (maiden, adoptive, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">NAME</td> <td>OTHER NAME(S) USED</td> </tr> <tr> <td>NAME</td> <td>OTHER NAME(S) USED</td> </tr> </table>	NAME	OTHER NAME(S) USED	NAME	OTHER NAME(S) USED																																												
NAME	OTHER NAME(S) USED																																															
NAME	OTHER NAME(S) USED																																															
CA 8 MC A. Does everyone live in California? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center;">YES</td> <td style="width: 15%; text-align: center;">NO</td> <td></td> </tr> </table>	YES	NO																																													
YES	NO																																															
B. Does everyone plan to stay in California permanently? If "NO", explain:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td rowspan="6" style="vertical-align: top;"> Calif. Resident: <input type="checkbox"/> Property <input type="checkbox"/> PA <input type="checkbox"/> Border Crossing Card <input type="checkbox"/> Visa </td> </tr> <tr> <td style="vertical-align: top;"> C. Does anyone own, lease or maintain a home outside California? If "YES", explain: </td> <td style="vertical-align: top;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table> </td> </tr> <tr> <td style="vertical-align: top;"> D. Is anyone currently getting public assistance outside California? If "YES", explain: </td> <td style="vertical-align: top;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table> </td> </tr> <tr> <td style="vertical-align: top;"> E. Is anyone planning to leave California for more than 30 days? If "YES", explain: </td> <td style="vertical-align: top;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table> </td> </tr> <tr> <td style="vertical-align: top;"> F. Did any family member enter the U.S. on a border crossing card or visa? 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FS 13 A. Do you pay someone else for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						COUNTY USE ONLY			
NAME OF PERSON YOU PAY		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN		NO. OF MEALS PER DAY	
CA FS MC 14 B. Does anyone pay you for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						Household Elects		ROOMER	
NAME OF PERSON WHO PAYS YOU		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN		NO. OF MEALS PER DAY	
BOARDER		HH MEMBER							
FS 14 Does anyone get food from any of the following programs? <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> • Communal dining facility for the elderly or disabled • Food distribution program operated by a Native American reservation • Other food program 									
NAME		NAME OF PROGRAM		WHO					
CA FS MC 15 A. Does anyone live in any of the following: <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						FS Eligible Institution: <input type="checkbox"/> YES <input type="checkbox"/> NO CA Eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		NAME OF CENTER, SHELTER, HOSPITAL, ETC.		DATE ENTERED					
MC B. Does the person who is in a hospital or nursing home have a spouse or minor child at home? <input type="checkbox"/> YES <input type="checkbox"/> NO						School Attendance Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO			
CA 16 Is every child age 6 to 16 attending school regularly? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", give the name(s) and explain why he/she is not attending regularly.									
CA FS MC 17 A. Is anyone age 16 or older enrolled in school, college, or a training program, or for Medi-Cal include child(ren) ages 14 and 15? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						School Enrollment Verif.: <input type="checkbox"/> YES <input type="checkbox"/> NO Date Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO FS Eligible Student <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		AGE		NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM					
NAME		AGE		NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM		UNITS/HOURS PER WEEK		EXPECTED DATE OF GRADUATION	
B. Complete below for anyone enrolled in college or attending a similar educational institution.						School Enrollment Verif.: <input type="checkbox"/> YES <input type="checkbox"/> NO Date Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO FS Eligible Student <input type="checkbox"/> YES <input type="checkbox"/> NO			
TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter		TUITION/FEES PER TERM \$		BOOKS, EQUIPMENT, ETC., PER TERM \$					
TRANSPORTATION COST PER WEEK \$		AMOUNT PAID BY CAR POOL MEMBERS \$		PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$		Financial Aid: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC 210 S-E			
CA 18 A. Is anyone under age 20 and pregnant or a parent? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:									
NAME		AGE		CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent		Referred to: <input type="checkbox"/> Cal-Learn <input type="checkbox"/> CA 25 <input type="checkbox"/> CA 25A <input type="checkbox"/> Referred to Welfare-to-Work			
SCHOOL STATUS, CHECK (✓) <input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Not Attending School (explain): <input type="checkbox"/> Currently Attending School <input type="checkbox"/> Other (explain):									
B. Has anyone received a cash bonus or penalty, or help with child care, transportation etc. from the Cal-Learn Program? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						Striker Regs Apply: <input type="checkbox"/> CA <input type="checkbox"/> FS <input type="checkbox"/> MC			
NAME		WHERE (COUNTY)		DATE(S) RECEIVED					
CA FS MC 19 Is anyone on strike? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:									
NAME OF STRIKER		NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM							
NAME OF UNION		GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE							
DATE WENT ON STRIKE									

(20) Has anyone, including children, worked or does any expect to go to work, including part-time and occasional work: Check (✓) "YES" or "NO" for each item.		YES	NO	COUNTY USE ONLY	
Has anyone stopped or refused work or training within the last 60 days?				(A) (✓) if exempt FS S/E Farmer	
Is anyone working or in training now?				CA	MC <input type="checkbox"/> FS Adult <input type="checkbox"/> Yes <input type="checkbox"/> No
Does anyone expect to be working or in training in the next two months?					<input type="checkbox"/> FS Child
If self-employed: For Food Stamps and Medi-Cal: list your business expenses on a separate sheet of paper.				(B) (✓) if exempt FS S/E Farmer	
For cash aid: Do you want your business expenses figured on:				CA	MC <input type="checkbox"/> FS Adult <input type="checkbox"/> Yes <input type="checkbox"/> No
check (✓) <input type="checkbox"/> 40% standard deduction <input type="checkbox"/> your actual business expenses? If actual , you must list your business expenses on a separate sheet of paper. If "YES" to above questions, complete below:					<input type="checkbox"/> FS Child
(A) NAME		NUMBER OF DAYS AND HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____		EMPLOYER NAME AND ADDRESS	
PAY DATE(S)	SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	WAGES BEFORE DEDUCTIONS \$ _____ per	LAST CHECK RECEIVED (DATE)	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW	
LAST DAY OF WORK/TRAINING		OCCUPATION		AMOUNT RECEIVED \$ _____ AMOUNT EXPECTED \$ _____	
AMOUNT EXPECTED BEFORE DEDUCTIONS \$		CHECK EXPECTED (DATE)		REASON FOR LEAVING JOB/TRAINING	
(B) NAME		NUMBER OF DAYS AND HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____		EMPLOYER NAME AND ADDRESS	
PAY DATE(S)	SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	WAGES BEFORE DEDUCTIONS \$ _____ per	LAST CHECK RECEIVED (DATE)	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW	
LAST DAY OF WORK/TRAINING		OCCUPATION		AMOUNT RECEIVED \$ _____ AMOUNT EXPECTED \$ _____	
AMOUNT EXPECTED BEFORE DEDUCTIONS \$		CHECK EXPECTED (DATE)		REASON FOR LEAVING JOB/TRAINING	

CA FS MC	(21) A. Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below and (✓) if for work or training.	Child Care Informing: <input type="checkbox"/> Trustline Informing (CCP 2) <input type="checkbox"/> Health & Safety Certification (CCP 5) <input type="checkbox"/> Dependent Care Verified
WHO GETS CARE	WHO PAYS	WHO GIVES CARE
		<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING
		AMOUNT/WHEN \$ _____ EVERY
WHO GETS CARE	WHO PAYS	WHO GIVES CARE
		<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING
		AMOUNT/WHEN \$ _____ EVERY

CA FS MC	B. Does anyone else pay all or part of your child care costs? <input type="checkbox"/> YES <input type="checkbox"/> NO Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc. If "YES", complete below:	DEP. CARE ELIGIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO FS: <input type="checkbox"/> YES <input type="checkbox"/> NO MC: <input type="checkbox"/> YES <input type="checkbox"/> NO Is there another person in household who could provide care? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, who: _____
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$
		WHO ELSE PAYS
		MONTHLY AMOUNT PAID \$
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$
		WHO ELSE PAYS
		MONTHLY AMOUNT PAID \$

FS MC	(22) Does anyone pay child or spousal support? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	Court Order on File <input type="checkbox"/> YES <input type="checkbox"/> NO Amount Ordered: \$ _____
WHO PAYS	FOR WHOM	AMOUNT PER MONTH \$

CA FS MC	(23) Has anyone applied for or received unemployment or disability insurance benefits in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	
NAME	DATE APPLIED	WHERE (COUNTY/STATE)
		DATE LAST RECEIVED
NAME	DATE APPLIED	WHERE (COUNTY/STATE)
		DATE LAST RECEIVED

CA	(24) Has anyone received a Diversion payment or services from the county? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF PERSON	NAME OF COUNTY	AMOUNT RECEIVED
		LIST SERVICES RECEIVED
		ESTIMATED VALUE OF SERVICES
		DATE RECEIVED

CA FS MC (25) Has any parent living in the home worked or been in training in the past 24 months. <input type="checkbox"/> YES <input type="checkbox"/> NO						COUNTY USE ONLY	
<div>If "YES", complete below:<ul style="list-style-type: none">● Include all work done outside the U.S.● Include work done in exchange for something besides money, such as rent, food, utilities or anything else.● Begin with each person's most recent job or training.</div>						PE/UIB Requirements Earnings from month prior to month of application App Date: _____ Earnings from _____ to _____	
						MO/YR (25) A (25) B	
A. NAME			IS HE/SHE A NATIVE AMERICAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF "YES", LIST TRIBE:							
Name and Address of Employer or Training Program (✓) Check, If Work or Training		When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training		When Employed MO DAY YR From To	Amount Paid
1. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
B. NAME			IS HE/SHE A NATIVE AMERICAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF "YES", LIST TRIBE:							
Name and Address of Employer or Training Program (✓) Check, If Work or Training		When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training		When Employed MO DAY YR From To	Amount Paid
1. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training		From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
FS (26) Are all members of the Food Stamp household citizens of the United States (U.S.)? <input type="checkbox"/> YES <input type="checkbox"/> NO							
If "NO", complete below for each Food Stamp household member who is not a citizen of the U.S.							
Name of Each Non-Citizen		A. How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S.?		B. While living in the U.S., in how many of the years reported in A did this person, their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S.?		C. While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S.?	
1.							
2.							
3.							
4.							
TOTAL						\$	\$
						(25) A	B
Tribal JOBS Referral							
UIB Verif(s) on file							
Must apply for							
Currently Receiving/Got/ or UIB eligible in last 12 months							
Ineligible Reason							
CA FS MC (27) Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO							
NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	(✓) STATUS <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	BRANCH OF SERVICE	DATES OF SERVICE	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	(✓) STATUS <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	BRANCH OF SERVICE	DATES OF SERVICE	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO		
COUNTY USE ONLY						(27)	
PRINCIPAL EARNER (PE) *				DATE OF APPLICATION		QUARTER OF APPLICATION	
*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.						CA 5 FS: Non-Citizen's Honorable Discharge Verif. <input type="checkbox"/> YES <input type="checkbox"/> NO	

CA FS MC	(28) A. Does anyone, including children, get or expect to get money from any source listed below? Check (✓) YES or NO for each item.	COUNTY USE ONLY <input type="checkbox"/> Casualty Unit Notified <input type="checkbox"/> CWC 6041 <input type="checkbox"/> DHS 6155 <input type="checkbox"/> Verif(s) on File Explain Anticip. Income Workers Comp: <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent																																																																																																
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> </tr> <tr> <td>Training Work Study, JTPA, GAIN, or other program</td> <td></td> <td></td> <td>Strike benefits</td> <td></td> <td></td> </tr> <tr> <td>Other training allowance</td> <td></td> <td></td> <td>Service Connected Benefits, Military allotment or pension Veterans Administration</td> <td></td> <td></td> </tr> <tr> <td>Educational grants, loans and scholarships</td> <td></td> <td></td> <td>Aid & Attendance Disability Educational related</td> <td></td> <td></td> </tr> <tr> <td>Welfare CalWORKs</td> <td></td> <td></td> <td>Railroad Retirement Disability Retirement</td> <td></td> <td></td> </tr> <tr> <td>Refugee Assistance</td> <td></td> <td></td> <td>Other federal, state, or local government agency Disability Retirement</td> <td></td> <td></td> </tr> <tr> <td>GA/GR (General Assistance/Relief)</td> <td></td> <td></td> <td>Other pension, sick leave or disability</td> <td></td> <td></td> </tr> <tr> <td>State Benefits UIB (Unemployment Insurance)</td> <td></td> <td></td> <td>Native American per capita payments</td> <td></td> <td></td> </tr> <tr> <td>DIB/SDI (State Disability)</td> <td></td> <td></td> <td>Winnings (gambling/lottery/bingo, prizes, etc.)</td> <td></td> <td></td> </tr> <tr> <td>Workers Compensation</td> <td></td> <td></td> <td>Sale of notes, contracts, trust deeds, promissory notes</td> <td></td> <td></td> </tr> <tr> <td>Support Child/spousal</td> <td></td> <td></td> <td>Other (Explain)</td> <td></td> <td></td> </tr> <tr> <td>(Money for) Medical bills or premiums</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Social Security Benefits Disability or SSI</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Retirement or survivors</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Loans, gifts, contributions</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Legal or Insurance settlements/ court actions pending</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		YES	NO		YES	NO	Training Work Study, JTPA, GAIN, or other program			Strike benefits			Other training allowance			Service Connected Benefits, Military allotment or pension Veterans Administration			Educational grants, loans and scholarships			Aid & Attendance Disability Educational related			Welfare CalWORKs			Railroad Retirement Disability Retirement			Refugee Assistance			Other federal, state, or local government agency Disability Retirement			GA/GR (General Assistance/Relief)			Other pension, sick leave or disability			State Benefits UIB (Unemployment Insurance)			Native American per capita payments			DIB/SDI (State Disability)			Winnings (gambling/lottery/bingo, prizes, etc.)			Workers Compensation			Sale of notes, contracts, trust deeds, promissory notes			Support Child/spousal			Other (Explain)			(Money for) Medical bills or premiums						Social Security Benefits Disability or SSI						Retirement or survivors						Loans, gifts, contributions						Legal or Insurance settlements/ court actions pending						
	YES	NO		YES	NO																																																																																													
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If "YES", complete below:						(✓) if exempt																																																																																												
NAME		SOURCE	AMOUNT (BEFORE DEDUCTIONS)	WHEN	HOW OFTEN	CA	FS	MC																																																																																										
			\$																																																																																															
			\$																																																																																															
CA FS MC	B. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise? If "YES", complete below:					<input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																												
NAME		WHAT	AMOUNT \$	WHEN																																																																																														
CA FS MC	(29) Does anyone get housing or rent, utilities, food or clothing free or in exchange for work? If "YES", complete below and check (✓) if free or in exchange:					<input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																												
ITEM RECEIVED		Free	Exchange	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM																																																																																												
Housing or rent					\$																																																																																													
Utilities					\$																																																																																													
Food					\$																																																																																													
Clothing					\$																																																																																													
CA FS MC	(30) A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.? If "YES", complete below. Include land and/or buildings in which the title is shared.					<input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																												
TYPE (LAND, CONDO, APARTMENT, HOUSE)		HOW DO YOU USE THIS PROPERTY? CHECK (✓)		YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME																																																																																									
		LIVE IN IT						\$	\$																																																																																									
Listed for sale <input type="checkbox"/> YES <input type="checkbox"/> NO		RENTAL PROPERTY																																																																																																
		OTHER (EXPLAIN):																																																																																																
TYPE (LAND, CONDO, APARTMENT, HOUSE)		HOW DO YOU USE THIS PROPERTY? CHECK (✓)		YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME																																																																																									
		LIVE IN IT						\$	\$																																																																																									
Listed for sale <input type="checkbox"/> YES <input type="checkbox"/> NO		RENTAL PROPERTY																																																																																																
		OTHER (EXPLAIN):																																																																																																
CA MC	B. Does anyone own a house that is not lived in now that he/she hopes to return to someday? If "YES", complete below:					<input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																												
OWNER OF PROPERTY			PROPERTY ADDRESS			EXPECTED DATE OF RETURN (IF KNOWN)																																																																																												
						Home Exempt <input type="checkbox"/> YES <input type="checkbox"/> NO Other Real Property Market Value \$ Amount Owed \$ Net Value \$ Lien Applicable <input type="checkbox"/> Listed for sale <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																												
						Home Exempt <input type="checkbox"/> YES <input type="checkbox"/> NO Other Real Property Market Value \$ Amount Owed \$ Net Value \$ Lien Applicable <input type="checkbox"/> Listed for sale <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																												
						Total Countable property: Page 7 (List totals on page 9) CA/FS \$ MC \$																																																																																												

CA
FS
MC**31 A. Does anyone, including children, have any of the following personal or business related resources?** Check (✓) each item either "YES" or "NO".Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Income tax refund		
Uncashed checks (on hand or elsewhere)			Native American or other trust funds (whether or not available)		
Savings accounts - children's and adult's			Notes, mortgages, deeds of trust, contracts of sale, etc.		
Checking accounts - whether or not they are used			IRA or Keogh plans, etc.		
Credit union accounts			Retirement funds which are available if you stop work (such as PERS, etc.)		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Employee deferred compensation plans		
Oil, mining, or mineral rights			Life insurance or annuity		
Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items			Life estate interest in any property		
			Long term care insurance		
			Other (explain)		

IF "YES", COMPLETE BELOW:

RESOURCE	BUSINESS RELATED	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$

CA
FS
MC**B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.?** ☐ YES ☐ NO

If "YES", complete below:

NAME	SOURCE OF MONEY	AMOUNT \$	HOW OFTEN	BUSINESS RELATED
				<input type="checkbox"/> YES <input type="checkbox"/> NO
		\$		<input type="checkbox"/> YES <input type="checkbox"/> NO

MC

32 Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services? ☐ YES ☐ NO

If "YES", complete below:

LIEN OR SECURED AMOUNT	TYPE AND LOCATION OF PROPERTY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED	NAME OF PROVIDER
\$			
\$			

CA
FS
MC**33 A. Does anyone own any personal property, such as:** ☐ YES ☐ NO

- boats, 3-wheelers, off-road vehicles, snowmobiles, mobile homes, campers, or trailers.
- guns; tools; or sporting equipment, etc.
- pets or livestock.
- jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

If "YES", complete below: Do not include wedding and engagement rings or heirlooms.

For cash aid and food stamps: list items worth more than \$100; **for Medi-Cal:** list jewelry worth more than \$100 and household goods or personal items worth more than \$500 per item.

ITEM (✓) IF LISTED FOR SALE	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED	ITEM (✓) IF LISTED FOR SALE	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED
<input type="checkbox"/>		\$	\$	<input type="checkbox"/>		\$	\$
<input type="checkbox"/>		\$	\$	<input type="checkbox"/>		\$	\$

B. Does anyone have any business property, including tools, inventory and materials, business equipment, etc. Include any property that is shared or held jointly with any other person(s)? If "YES", complete below and (✓) if listed for sale: ☐ YES ☐ NO

ITEM	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED	ITEM	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED
<input type="checkbox"/>		\$	\$	<input type="checkbox"/>		\$	\$
<input type="checkbox"/>		\$	\$	<input type="checkbox"/>		\$	\$

COUNTY USE ONLY

☐ Trust Fund/Not Court Ordered

☐ Court Petitioned Date _____

☐ Resource Verified: Explain how: _____

Total Value = _____

☐ Burial Reserve or Trust (MCO) Amount Owed \$ _____

☐ Revocable

☐ Irrevocable

☐ Designated Fund and Current Value \$ _____

☐ CA Restricted Account

Check (✓) if exempt

CA	FS	MC

Verified: ☐ YES ☐ NOLien Applicable: ☐ YES ☐ NOSecurity Agreement: ☐ YES ☐ NOMC 174 completed and sent: ☐ YES ☐ NO

- ☐ Owned Jointly
- ☐ Owned Separately

☐ Personal Property \$500 + for Pickle Program☐ Listed for sale (Specify): _____

Total Countable property: Page 8 (List totals on page 9)

CA/FS \$ _____

MC \$ _____

☐ Listed for sale (Specify): _____

CA MC 34 A. Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else? (List any property sold or traded within the last 12 months for cash aid and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when: ☐ YES ☐ NO

MC B. Has anyone received money from insurance or court settlements, inheritance, lottery or back pay in the last 2 1/2 years (30 months)? If "YES", complete below: ☐ YES ☐ NO

NAME	SOURCE	DATE RECEIVED	AMOUNT
			\$

CA FS MC 35 Does anyone own, have the use of or have their name on the registration of any motor vehicle, e.g., mobile home, camper, snowmobile or boat, even if not running? If "YES", complete below. Look at your registration to get facts for each vehicle: ☐ YES ☐ NO

	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
OWNER OF VEHICLE						
NAME OF PERSON WHO USES VEHICLE						
YEAR/MAKE/MODEL						
LICENSE NUMBER						
ESTIMATED VALUE	\$		\$		\$	
BALANCE OWED	\$		\$		\$	
LICENSED	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
LEASED	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HOW DO YOU USE THE VEHICLE? Check (✓) each item YES OR NO	YES	NO	YES	NO	YES	NO
As a Home						
To go to work or training or for job search						
For work, self-support, or self-employment						
Needed for disabled household member						
To get household's fuel or water						

COUNTY USE ONLY - VEHICLES

CASH AID/FOOD STAMPS	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)	<input type="checkbox"/> YES (Exclude)	<input type="checkbox"/> NO Go to B	<input type="checkbox"/> YES (Exclude)	<input type="checkbox"/> NO Go to B	<input type="checkbox"/> YES (Exclude)	<input type="checkbox"/> NO Go to B
(B) 1. Is vehicle for home use? (Allow one vehicle only) OR 2. Is vehicle used for job search, employment or training? (63-501.523)	<input type="checkbox"/> YES Go to C Use Excess Value	<input type="checkbox"/> NO Go to C and D. Use Greater Value	<input type="checkbox"/> YES Go to C Use Excess Value	<input type="checkbox"/> NO Go to C and D. Use Greater Value	<input type="checkbox"/> YES Go to C Use Excess Value	<input type="checkbox"/> NO Go to C and D. Use Greater Value

MEDI-CAL

	(1)	(2)	(3)
DMV/YR/Class Code			\$
Vehicle Market Value	\$	\$	\$
Less Encumbrances	\$	\$	\$
Net Value	\$	\$	\$
Exempt	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Pickle Program:			
Is RV used primarily as a home?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

TOTALS: VEHICLE CA/FS
Excess Value \$
Equity Value \$

Grand Total Countable property
(List totals from pages 7, 8, and 9)
Page CA/FS MC
(9) \$ \$
(8) \$ \$
(7) \$ \$
Total \$ \$

COUNTY USE ONLY

Closed Bank Accts:
☐ CA in last 12 months
☐ Medi-Cal in last 30 months

☐ Adequate Consideration
☐ Spenddown

LTC ONLY
Total Nonexempt Property \$

Compute Vehicle Valuation in Section Below:

☐ MC: Use Pickle Handbook
☐ Verifications viewed
☐ Leased vehicle:
☐ (1) ☐ (2) ☐ (3)

Vehicle value
(Enter Date of blue book issue or other documentation)

(1) Date: \$

(2) Date: \$

(3) Date: \$

(C) Fair Market Values-CA/FS

FMV			
Minus \$	Minus \$	Minus \$	Minus \$
Excess Value			

(D) Equity Values-CA/FS

FMV			
Minus Encumbrance			
Equity Value			

CA
FS
MC**36) A. Does anyone have any housing costs?**☐ YES ☐ NO

If "YES", complete below:

HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	\$	\$	\$	
House (mortgage) payment	\$	\$	\$	
Property taxes (if not in house payment)	\$	\$	\$	
Insurance (if not in house payment)	\$	\$	\$	
Other (explain)	\$	\$	\$	

CA
FS
MC**B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc. If "YES", complete below:**☐ YES ☐ NO

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH	HOW OFTEN BILLED
		\$	
		\$	

COUNTY USE ONLYHousing verified: ☐ YES ☐ NO

Total housing \$ _____

Shared housing: ☐ YES ☐ NO

FS

37) A. Does anyone have any utility costs?☐ YES ☐ NO

If "YES", complete below:

UTILITY COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Gas or other fuel	\$	\$	\$	
Electricity or other fuel	\$	\$	\$	
Is the gas or electricity or other fuel used to heat or cool your house?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Water	\$	\$	\$	
Sewage	\$	\$	\$	
Garbage or trash	\$	\$	\$	
Telephone (Basic rate for one phone plus tax)	\$	\$	\$	
Installation of utilities	\$	\$	\$	
Other (explain)	\$	\$	\$	

FS

B. Does anyone else pay all or part of these utility costs? Include a relative/friend not living in the home, Low Income Energy Assistance, etc. If "YES", complete below:☐ YES ☐ NO

TYPE OF UTILITY COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED

Utilities verified: ☐ YES ☐ NOMetered: ☐ YES ☐ NO

Client elects

☐ ActualIf Actual, Total Utilities
\$ _____☐ SUA

SUA prorated:

☐ YES ☐ NO

FS

38) You can authorize someone else in your household or someone outside your household to pick up your food stamps or to use them to buy food for you. If you would like to authorize someone, complete below:☐ F.S. I.D. Issued

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		()

CERTIFICATION

I understand that the disqualification and/or welfare fraud penalties I will get if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

I understand that:

- I must apply for and keep any available health coverage if no cost is involved; if I don't my Medi-Cal will be denied or stopped.
- If I do not follow cash aid rules, I may be fined up to \$10,000 and/or sent to jail/prison for 3 years.
- If I am found guilty by a court of law or an administrative hearing of committing certain types of fraud, my cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.
- If I do not follow food stamp rules, my food stamps will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
 - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
 - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;
 - I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever;
 - I filed two or more applications for food stamps at the same time and gave the county false identity or residence information, my food stamps can be stopped for 10 years.

I also understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident alien (LPR), (b) an amnesty alien with a valid and current I-688, or (c) an alien permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the INS.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law for a felony or attempted felony, or is in violation of their parole or probation cannot get cash aid/or food stamps.
- Anyone who has been convicted of a drug related felony for possession, use, or distribution of illegal drugs since August 22, 1996, cannot get food stamps or if convicted since January 1, 1998, cannot get cash aid.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)			DATE
SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

COUNTY USE ONLY																				
		REGULATIONS MET?								REGULATIONS MET?						FOOD STAMP TESTS				
		CA		FS		MC				CA		FS		MC				YES	NO	NA
		YES	NO	YES	NO	YES	NO			YES	NO	YES	NO	YES	NO					
Residency								Property—Within limits and verified amount \$								Categorically Eligible				
Deprivation								Work registration/ FSET/ABAWDs								Gross Income Test				
Age								Sponsored alien								Household Size				
Citizen/Eligible non-citizen								Federal participation established (If "NO", explain)								Gross Monthly Income \$				
School enrollment								Referred for Health Care Options (HCO) Presentation (Managed Care)								Gross Income Eligible				
Pregnancy verified/WIC Referral																Separate HH Income Test				
SSN																Household Size				
Income—Gross and net income																Gross Monthly Income \$				
																Eligible for Separate HH Status				
																Aged/Disabled				
																DFA 285-C				
																If "NO", why:				

AU Size: <input type="checkbox"/> INELIGIBLE (REASON)	Non-AU Size: <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> DIVERSION <input type="checkbox"/> REDETERMINATION <input type="checkbox"/> MAP EXEMPTION	AU/MFBU Size: AUTHORIZATION DATE EFFECTIVE DATE ELIGIBILITY WORKER'S SIGNATURE DATE SUPERVISOR'S SIGNATURE (COUNTY OPTION) DATE
--	---	---

FS: <input type="checkbox"/> INELIGIBLE (REASON)	HH Size: <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> RECERTIFICATION
AUTHORIZATION DATE ELIGIBILITY WORKER'S SIGNATURE DATE SUPERVISOR'S SIGNATURE (COUNTY OPTION) DATE	AUTHORIZATION DATE ELIGIBILITY WORKER'S SIGNATURE DATE SUPERVISOR'S SIGNATURE (COUNTY OPTION) DATE

STATEMENT OF FACTS FOR AN ADDITIONAL PERSON*(Supplemental Application for Food Stamps and Request for Cash Aid)*

INSTRUCTIONS: Fill out this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper. Fill in the answers for all the questions about the benefits you are asking for. The "CA" for cash aid and "FS" for food stamps listed to the left side of each question tell you which questions are for which program.

If you get cash aid, and you want aid for the new person, this form must be filled out by either the adult caretaker relative who is now getting cash aid or the new person, unless the new person is a child.

For Food Stamp households, which do not get cash aid or do not want cash aid for the new person, this form may be completed by a household member, an authorized representative or the new person.

PLEASE PRINT IN INK

CA ① Name of Person Completing Form (First, Middle, Last)
FS

CA ② List new person in the home, including a newborn.
FS

NAME (First Middle Last)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO	
SOCIAL SECURITY NUMBER - -	BIRTHDATE - -	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	IS HE/SHE A PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
BIRTHPLACE (City/State/Country)	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	SCHOOL STATUS (✓) <input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Currently Attending School <input type="checkbox"/> Not Attending School (Explain):	
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		
RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO		ANY OTHER NAME USED, BELOW: (Maiden, adoptive, etc.)	

CA ③ Has he/she applied for or received benefits in the past, such as: cash aid, food stamps homeless assistance, Medi-Cal, Refugee Cash Assistance? ☐ YES ☐ NO
FS If "YES", explain:

WHEN	WHERE (County, State, or Country)	TYPE OF BENEFIT

CA ④ Is he/she a child under age 19? If "YES", complete below: ☐ YES ☐ NO

MOTHER'S NAME (✓) Lives in Home	FATHER'S NAME (✓) Lives in Home	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply) <input type="checkbox"/> Absence <input type="checkbox"/> Unemployment <input type="checkbox"/> Incapacity <input type="checkbox"/> Death
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

CA ⑤ Has he/she been in the U.S. military service or the spouse, parent or child of a person who has been in the military service? ☐ YES ☐ NO
FS If "YES", explain:

LIST NAME, BRANCH OF SERVICE, ETC.	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO
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CA ⑥ Has he/she lived in California for the last 12 months in a row? ☐ YES ☐ NO
Complete below:

LAST PLACE OF RESIDENCE (City, State)	DATE ARRIVED IN CALIFORNIA

CA ⑦ Does he/she presently live in California and intend to continue living here? ☐ YES ☐ NO
FS If "NO", explain:

COUNTY USE ONLY

CASE NAME
CASE NUMBER
WORKER NAME
WORKER NUMBER
DATE RECEIVED

VERIFIED:	YES	NO
SSN		
FS ID		
Blind/Deaf/Disabled		
Residency		
DFA 285-C Comp.		
Referred to Cal-Learn		
CA 25 Completed		
CA 25 A Completed		
Referred to GAIN		
Citizen		
Eligible Non-citizen		
Sponsored		
SAVE		
Date of Entry to U.S.		
Excluded HH Member Code		
Work/Training/GAIN Code		

VERIFIED: ☐ YES ☐ NO
Deprivation

CA 5 ☐ YES ☐ NO

Date Initiated _____

Apply RFG: ☐ YES ☐ NO

State _____
RFG MAP _____
RFG Months _____

CA ⑧ A. Is he/she a foster child(ren) living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO FS	COUNTY USE ONLY		
FS B. Do you want the foster child and their foster care income included in the Food Stamp case? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> AFDC and FC Eligible/ CR Chooses: Child: <input type="checkbox"/> AFDC <input type="checkbox"/> FC CR: <input type="checkbox"/> AFDC <input type="checkbox"/> None		
CA ⑨ A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO FS	VERIFIED: School Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No FS Eligible Student <input type="checkbox"/> Yes <input type="checkbox"/> No		
NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO
CA B. Complete below if he/she is enrolled in college or attending a similar educational institution. FS			
TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$	
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED	
TRANSPORTATION COST PER WEEK \$	AMOUNT PAID BY CARPOOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.,) PER DAY \$	
CA ⑩ Has he/she had cash aid or food stamps stopped for a period of time or forever due to: non-cooperation during a quality control review, work or training sanctions, or due to welfare fraud or an Intentional Program Violation? <input type="checkbox"/> YES <input type="checkbox"/> NO FS If "YES", complete below:			
WHY	WHEN	WHAT COUNTY/STATE	
CA ⑪ Is he/she hiding or running from the law for a felony, an attempted felony, or for a parole or probation violation? <input type="checkbox"/> YES <input type="checkbox"/> NO FS			
FS ⑫ Does he/she buy food and fix meals separately from others in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO			
FS ⑬ Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO			
FS ⑭ Does he/she pay you for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO			
CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY
FS ⑮ Does he/she get food from any of the following programs? <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> Communal dining facility for the elderly or disabled Food distribution program operated by a Native American reservation Other food program If "YES", complete below:			
NAME OF PROGRAM			

CA (16) Is he/she working now or expecting to be working in the next two months? If "YES", complete below. Attach paystubs or other proof of earnings. FS (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form). <div style="text-align: right;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div>						COUNTY USE ONLY			
EMPLOYER NAME		SELF EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO		OCCUPATION		DAYS/HOURS WORKED PER MONTH		<input checked="" type="checkbox"/> if Exempt <input type="checkbox"/> CA <input type="checkbox"/> FS Adult <input type="checkbox"/> FS Child	
PAY DATE(S)		WAGES BEFORE DEDUCTIONS \$ _____ per		TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO		FS S/E Farmer <input type="checkbox"/> Yes <input type="checkbox"/> No Verification(s) on file: <input type="checkbox"/> Yes <input type="checkbox"/> No			
CA (17) A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO Child Care Informing Given to Client:			
NAME OF PERSON WHO RECEIVES CARE			NAME OF PERSON WHO GIVES CARE			MONTHLY AMOUNT PAID \$ _____		Trustline Informing (CCP 2) Health & Safety Certification (CCP 5) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
NAME OF PERSON WHO RECEIVES CARE			NAME OF PERSON WHO GIVES CARE			MONTHLY AMOUNT PAID \$ _____		Dependent Care Eligible CA FS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
CA (17) B. Does he/she get child care costs paid for them? FS Include costs paid by a relative or friend, Department of Education, Student Aid Block Grant, Cal-Learn, TCC, NET, GAIN, SCC, CAAP, etc. If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF CHILD			WHO PAYS			MONTHLY AMOUNT PAID \$ _____			
NAME OF CHILD			WHO PAYS			MONTHLY AMOUNT PAID \$ _____			
CA (18) Has he/she stopped or refused work or training in the last 60 days? FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM				Did this person get or expect to get wages or benefits this month? If "YES", complete below.				YES NO Emp. Statement <input type="checkbox"/> <input type="checkbox"/> Good Cause Determ <input type="checkbox"/> <input type="checkbox"/> Voluntary Quit <input type="checkbox"/> <input type="checkbox"/>	
				LAST PAYCHECK RECEIVED (DATE)		AMOUNT BEFORE DEDUCTIONS \$ _____		<input type="checkbox"/> CA: 30 days <input type="checkbox"/> FS: 60 days	
				EXPECTED CHECK (DATE)		AMOUNT BEFORE DEDUCTIONS \$ _____			
NUMBER OF HOURS OF WORK/TRAINING Last Month _____ This Month _____				LAST DAY OF WORK/TRAINING		TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO			
				REASON FOR LEAVING JOB/TRAINING					
CA (19) Is he/she on strike? FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM				NAME OF UNION		CA FS		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
				DATE WENT ON STRIKE					
				GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE \$ _____					
CA (20) Does he/she pay child or spousal support? FS If "YES", complete below:						<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF CHILD OR SPOUSE				AMOUNT PER MONTH \$ _____		COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO		Court Order on File <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Ordered \$ _____	
CA (21) Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.?						<input type="checkbox"/> YES <input type="checkbox"/> NO			
If "YES", complete below:									
TYPE BENEFIT	AMOUNT	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	HOW OFTEN (Weekly, Monthly, Etc.)	DATE EXPECTED TO START AND STOP		<input checked="" type="checkbox"/> if Exempt CA FS	
		\$ _____				START:			
						STOP:			

CA (22) Does he/she own or is he/she buying any real estate, such as land ☐ YES ☐ NO
 FS and/or buildings anywhere, including outside the U.S.?

If "YES", complete below:

TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	ESTIMATED VALUE	AMOUNT OWED
			\$	\$

COUNTY USE ONLY

Home Exempt ☐ Yes ☐ No

Other Real Property

Market Value \$

Amount Owed \$

Net Value \$

Lien Applicable ☐ Yes ☐ No

CA (23) A. Does he/she have any of the following resources? ☐ YES ☐ NO
 FS If "YES" check (✓) each item and explain below:

RESOURCE	YES	NO	RESOURCE	YES	NO
Checks or Money (at home or elsewhere)			Trust Funds		
Checking/Savings/Credit Union Account			Stocks, Bonds, Certificates, IRAs, Retirement Funds		
Notes, Mortgages, Trust Deeds, Sales Contracts			Other (list below)		

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	(✓) if Exempt
				\$	AFDC FS
				\$	

CA B. Does he/she get income from any of these resources, such as ☐ YES ☐ NO
 FS interest, dividends, etc.?
 If "YES," list each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	\$	
	\$	

CA (24) Does he/she own, lease, or use any motor vehicles, such as a ☐ YES ☐ NO
 FS car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.?
 If "YES", complete below:

NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED
<input type="checkbox"/> Leased				<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

(✓) If Exempt Leased ☐ Exempt ☐ Leased
 Vehicle Valuation

CA (25) Does he/she own or use personal property which cost at least \$100 for ☐ YES ☐ NO
 FS each item or is now worth at least \$100 each, such as: jewelry, equipment, instruments, livestock, etc.? Do **not** list clothing, wedding rings, rugs, furniture, appliances, or other household furnishings.
 If "YES", complete below:

OWNER	NAME OF ITEM	DATE BOUGHT	PURCHASE PRICE OR CURRENT VALUE	BALANCE OWED
			\$	\$
			\$	\$

☐ Owned Jointly
☐ Owned Separately
 Net Market Value
 \$

CA (26) Has he/she sold, transferred or given away any real or personal property ☐ YES ☐ NO
 FS within the last 2 years for cash aid and within the last 3 months for food stamps?
 If "YES", explain below:

Closed Bank Accounts:
☐ Food Stamps in last 3 months

CA (27) Does he/she have any of the following insurance coverage: life, burial, ☐ YES ☐ NO
 FS disability or mortgage?
 If "YES", complete below:

NAME OF INSURANCE COMPANY	POLICY NUMBER	PREMIUM PAID BY (NAME)	AMOUNT PAID
			\$

Total CSV
 (1) _____
 (2) _____
 Total Countable Property:
 Items 22-27
 AFDC \$ _____
 FS \$ _____

CA (28) Does he/she have health or hospitalization insurance, including insurance ☐ YES ☐ NO
 FS paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.?
 If "YES", complete below:

NAME OF INSURANCE COMPANY	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
		\$	

☐ Health Care Options
 Explanation Given
 Referral _____
 NA _____
☐ DHS 6155
☐ DFA 285-C
 Medicare Gross Premium
 \$ _____

CA 29 Did he/she get medical/ pregnancy treatment this month or in the three months before this month? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					COUNTY USE ONLY		
NAME OF PERSON RECEIVING CARE		MONTHS OF CARE		WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?	
				YES NO		YES NO	

CA 30 Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					<input type="checkbox"/> DHS 6155	
NAME OF INSURANCE COMPANY		PREMIUM AMOUNT		HOW OFTEN PAID		
		\$				
		\$				

CA 31 Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					VERIFIED: Higher/Lower MAP <input type="checkbox"/> Yes <input type="checkbox"/> No Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C	
TYPE OF PROBLEM		DATE PROBLEM STARTED		EXPECTED DATE OF RECOVERY		

CA 32 A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? FS Check (✓) each item YES or NO:						CA Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____ VERIFIED: CA <input type="checkbox"/> Yes <input type="checkbox"/> No FS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C	
		YES	NO			YES	NO
Special diet--prescribed by a doctor				Very high use of utilities			
Special transportation need				Special laundry service			
Special telephone or other equipment				Other (specify):			
Housework (no one in the home can do it)							
If "YES", explain:							

CA B. Does he/she get In-Home Supportive Services (IHSS)? <input type="checkbox"/> YES <input type="checkbox"/> NO FS If "YES", how much does he/she pay each month? \$ _____					<input type="checkbox"/> DFA 285-C	
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CA 33 The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility. Check (✓) each item YES or NO.					<input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____ <input type="checkbox"/> Referral	
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention program (CHDP) for eligible members of your family under age 21.			YES	NO		
• Do you want more information about CHDP Services?						
• Do you want CHDP medical services?						
• Do you want CHDP dental services?						
• Do you need help making appointments or with transportation to CHDP Services?						
B. If anyone in the family is pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?						
C. Is anyone in the family breastfeeding a child? If "YES", was the birth within the last 12 months? If "YES" checked to 33B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.						
D. Do you or any family member want free or low-cost family planning services ? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.						

CERTIFICATION

I understand the disqualification and/or welfare fraud penalties I will get if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

I understand that:

- If I do not follow cash aid rules, my cash aid can be stopped for 6 months for the first violation, 12 months for the second, and forever for the third. And I may also be fined up to \$5,000 and/or sent to jail/prison for 3 years.
- If I give false or incomplete facts, I may be fined or sent to jail or prison if I am found guilty of committing perjury.
- If I file more than one application for cash aid so I can get cash aid in more than one case at the same time, or give the county false proof for an ineligible child or for a child that does not exist, my cash aid can be stopped for 2 years, 4 years, or forever.
- If I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
 - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation;
 - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;
 - I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever;
 - I gave the county false identity or residence information so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.

I also understand that:

- I must apply for and keep any available health coverage if no cost is involved; if I don't, my Medi-Cal will be denied or stopped.
- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, etc.
- A Social Security Number (SSN) is required by law and will be matched with other records to be sure that I am not getting aid in more than one case, or in another county or state.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution, may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law for a felony or attempted felony, or is in violation of their parole or probation cannot get food stamps.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (OTHER PARENT IN THE HOME, IF APPLYING FOR CASH AID)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT	DATE

EW SIGNATURE

DATE

APPLICATION FOR FOOD STAMPS - PART 2

INSTRUCTIONS: Please fill in this form in ink and bring or mail it to the County Welfare Office. The application must be signed by an adult household member or by the Authorized Representative. If it is completed by an adult who is not a member of your household, attach a written authorization signed by the head of the household or another household member.

If you need more space, attach another sheet of paper.

Tell your worker if you need help in getting proof or filling out this form.

				COUNTY USE ONLY	
1 NAME (HEAD OF HOUSEHOLD)		2 ARE YOU HOMELESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ARE YOU STAYING IN THE HOME OF SOMEONE ELSE? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE BEGAN STAYING IN THIS HOME:		CASE NAME	
HOME ADDRESS (NUMBER, STREET)		MAILING ADDRESS (IF DIFFERENT OR LOCATION OF WHERE YOU STAY IF YOU ARE HOMELESS)		CASE NUMBER	
CITY STATE ZIP CODE		CITY STATE ZIP CODE		WORKER DATE RCD	
HOME PHONE NUMBER ()		DAYTIME OR MESSAGE PHONE NUMBER ()		<input type="checkbox"/> New <input type="checkbox"/> Recert	
3 Provide the following information on each person living in the home, including yourself. You must list all people in the home whether or not they want food stamps.				<input type="checkbox"/> Residency verified	
				<input type="checkbox"/> Length of time in another's home:	
				<input type="checkbox"/> FS ID verified	
A YOUR NAME (FIRST MIDDLE LAST)		CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code	
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		RELATIONSHIP TO HEAD OF HOUSEHOLD		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHDATE / /		BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	
		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No	
B NAME (FIRST MIDDLE LAST)		CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code	
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		RELATIONSHIP TO HEAD OF HOUSEHOLD		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHDATE / /		BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	
		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No	
C NAME (FIRST MIDDLE LAST)		CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code	
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		RELATIONSHIP TO HEAD OF HOUSEHOLD		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHDATE / /		BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	
		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No	
D NAME (FIRST MIDDLE LAST)		CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code	
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		RELATIONSHIP TO HEAD OF HOUSEHOLD		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHDATE / /		BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	
		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No	

COUNTY USE ONLY

FS Non-HH/Excluded Member (63-402)			FS and ABAWD Work/Training Exemptions (63-407, 410)		
1. Separate HH (Purchase/prepare) (.12, .13)	10. Workfare sanctioned (.225)	a. Under 16/60 or older	h. 1/2 time student in school, training or higher education		
2. Separate HH (Elderly/disabled) (.17)	11. SSI/SSP recipient (.226)	a.(1) 16/17 not head of household or in school or training at least half time			
3. Roomer(must be listed in (7)) (.211)	12. Ineligible student (.227)	b. Mentally/physically unfit for work	ABAWD Exemptions:		
4. Live-in attendant (.212)	13. Work req. disqualified (.228)	c. Mandatory participant in Welfare to Work activities	1. ABAWD w/exemption of b,d,e,f, or h		
5. Other Shared Living Quarters (.213)	14. Questionable citizenship (403.31)	d. Cares for child under 6/incapacitated person	2. Under 18, 50 or older		
6. Ineligible alien (.221)	15. Vol. Quit ineligible (408.2)	e. UIB registered	3. Pregnant		
7. Boarder (must be listed in (7)) (.3)	16. Ineligible/disqualified ABAWD (410.4)	f. Participant in drug/alcohol program	4. Caring for any dependent child		
8. SSN disqualified (.222)	17. Fleeing Felon/parole or probation violator (.224)	g. Employed 30 hour week/min. x 30	5. Lives in ABAWD exempt area		
9. IPV disqualified (.223)	18. Drug Felon (.229)				

E NAME (FIRST MIDDLE LAST)			CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		COUNTY USE ONLY			
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO HEAD OF HOUSEHOLD		FS/ABAWD Code		Non-HH/Excl'd Member Code	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /	BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No		
				Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No		
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No				
F NAME (FIRST MIDDLE LAST)			CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code			
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO HEAD OF HOUSEHOLD		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /	BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No		
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No				
G NAME (FIRST MIDDLE LAST)			CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code			
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO HEAD OF HOUSEHOLD		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /	BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No		
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No				
H NAME (FIRST MIDDLE LAST)			CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code			
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO HEAD OF HOUSEHOLD		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /	BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No		
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No				
I NAME (FIRST MIDDLE LAST)			CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code			
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO HEAD OF HOUSEHOLD		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /	BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No		
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No				
J NAME (FIRST MIDDLE LAST)			CITIZEN/NONCITIZEN STATUS: (✓) <input type="checkbox"/> U.S.Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		FS/ABAWD Code Non-HH/Excl'd Member Code			
SOCIAL SECURITY NUMBER		SEX (CHECK ONE) <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO HEAD OF HOUSEHOLD		Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Elig. Noncitizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE / /	BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		SAVE <input type="checkbox"/> Yes <input type="checkbox"/> No	
EATS, BUYS FOOD OR FIXES MEALS WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO		60 OR OLDER AND UNABLE TO BUY FOOD AND FIX MEALS? <input type="checkbox"/> YES <input type="checkbox"/> NO		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		DFA 285C Compltd <input type="checkbox"/> Yes <input type="checkbox"/> No		
				Pregnant (ABAWD) <input type="checkbox"/> Yes <input type="checkbox"/> No				
4 A. Is there a foster child(ren) living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who:								
B. Do you want the foster child(ren) and their foster care income included in the Food Stamp case? <input type="checkbox"/> YES <input type="checkbox"/> NO								
5 Does anyone get food from any program, such as: <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> communal dining facility for the elderly or disabled food distribution program operated by a Native American Reservation any other food program If "YES", explain below:								
NAME	NAME OF PROGRAM		NAME	NAME OF PROGRAM				

6 Does anyone live in: <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> homeless shelter shelter for battered women federally subsidized housing for the elderly reservation for Native Americans <ul style="list-style-type: none"> drug or alcoholic rehabilitation center group living arrangement for the blind/disabled penal institution/correctional facility psychiatric hospital/mental institution If "YES", explain below:						COUNTY USE ONLY					
NAME		NAME OF CENTER, SHELTER, ETC.		DATE ENTERED		DATE EXPECTED TO LEAVE		FS Eligible Facility <input type="checkbox"/> YES <input type="checkbox"/> NO			
7 A. Do you pay anyone for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:								Household Elects Boarder HH Member ROOMER			
NAME OF PERSON YOU PAY		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN				NO. OF MEALS PER DAY	
B. Does anyone pay you for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:								Boarder HH Member ROOMER			
NAME OF PERSON WHO PAYS YOU		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN				NO. OF MEALS PER DAY	
8 Is anyone 18 years of age or older enrolled in school, college or a training program? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:								FS Eligible student <input type="checkbox"/> YES <input type="checkbox"/> NO FS Eligible student <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		AGE		NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM ENROLLED IN		ENROLLED (✓) <input type="checkbox"/> FULL TIME <input type="checkbox"/> HALF TIME <input type="checkbox"/> OTHER				UNITS/HOURS PER WEEK WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME		AGE		NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM ENROLLED IN		ENROLLED (✓) <input type="checkbox"/> FULL TIME <input type="checkbox"/> HALF TIME <input type="checkbox"/> OTHER				UNITS/HOURS PER WEEK WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO	
9 Is anyone, including children, currently working or expecting to work in the next two months? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below: (NOTE: If self-employed, list and explain costs on a separate sheet of paper and attach to this form.)								Earnings & Expenses <div style="display: flex; justify-content: space-between;"> <div> Exempt Income <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Verif(s) on file </div> <div> Self-employed farmer <input type="checkbox"/> YES <input type="checkbox"/> NO </div> </div>			
NAME OF PERSON		OCCUPATION		SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO		EMPLOYER'S NAME					
HOURS WORKED PER MONTH		PAY DATE(S)		WAGES BEFORE DEDUCTIONS \$ PER		TIPS OR COMMISSIONS <input type="checkbox"/> VERIFIED					
NAME OF PERSON		OCCUPATION		SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO		EMPLOYER'S NAME					
HOURS WORKED PER MONTH		PAY DATE(S)		WAGES BEFORE DEDUCTIONS \$ PER		TIPS OR COMMISSIONS <input type="checkbox"/> VERIFIED					
10 Is anyone on strike? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:								Striker Regs Apply <input type="checkbox"/> YES <input type="checkbox"/> NO Gross Monthly Income Earned from this Job Before the Strike: \$			
NAME OF STRIKER		NAME OF UNION		NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM		DATE WENT ON STRIKE					
11 Has anyone stopped or refused work or training in the last 60 days? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:								Voluntary Quit <input type="checkbox"/> YES <input type="checkbox"/> NO Good Cause <input type="checkbox"/> YES <input type="checkbox"/> NO Voluntary Quit <input type="checkbox"/> YES <input type="checkbox"/> NO Good Cause <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF PERSON		NAME AND ADDRESS OF EMPLOYER/TRAINING		REASON FOR LEAVING		CHECKS OR BENEFITS EXPECTED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", HOW MUCH BEFORE DEDUCTIONS \$					
HOURS OF WORK/TRAINING		LAST DAY OF WORK OR TRAINING		DATE LAST PAYCHECK RECEIVED							
NAME OF PERSON		NAME AND ADDRESS OF EMPLOYER/TRAINING		REASON FOR LEAVING		CHECKS OR BENEFITS EXPECTED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", HOW MUCH BEFORE DEDUCTIONS \$					
HOURS OF WORK/TRAINING		LAST DAY OF WORK OR TRAINING		DATE LAST PAYCHECK RECEIVED							
12 Is there a child or disabled person in the household who needs care from another household member? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:											
NAME OF PERSON NEEDING CARE		NAME OF PERSON(S) PROVIDING CARE		HOURS OF CARE DAILY							

13

Are all members of the household citizens of the United States?☐ YES ☐ NO**COUNTY USE ONLY**

If "NO", complete the following questions for each member who is NOT A CITIZEN:

List Name of Person Who Is A Noncitizen	A. How many years total have you, your spouse, and/or your parents, (before you were 18 years old) lived in the United States?	B. In how many of the years reported in 13A, did you, your spouse or your parents (before you were 18 years old) earn money by working in the United States?	C. How many total years did you, your spouse, or your parents (before you were 18 years old) work in the United States or for a U.S. company while not living in the United States?	D. Check below if noncitizen is on active duty in the U.S. Military, a veteran, or the spouse or dependent child of someone on military active duty or a veteran. If checked, complete information below.
1.				<input type="checkbox"/>
2.				<input type="checkbox"/>
3.				<input type="checkbox"/>
4.				<input type="checkbox"/>
5.				<input type="checkbox"/>
6.				<input type="checkbox"/>
7.				<input type="checkbox"/>
8.				<input type="checkbox"/>

NAME OF ACTIVE DUTY MILITARY PERSON OR VETERAN

BRANCH OF SERVICE

DATES SERVED

☐ 40 Quarters Verified
☐ Client Release For Social Security On File
 Honorable Discharge Verified
☐ YES ☐ NO

14

Does anyone, including children, get or expect to get money from any source listed below?

Check (✓) YES or NO for each item. If you check YES, complete information below.

	YES	NO		YES	NO
Training, Work Study, JTPA, GAIN, other Training Allowances			Veterans Administration: Disability, GI Bill VEAP, Aid & Attendance		
Educational Grants, Loans and Scholarships			Military Allotment or Pension		
Cash Assistance: CalWORKs, Refugee Assistance, GA/GR (General Assistance/Relief)			Railroad Retirement Board: Disability or Retirement		
Social Security Benefits: SSI, Other Disability, Retirement or Survivors Benefits			Other Federal, State or Local Government Agency: Disability or Retirement		
State Benefits: UIB/DIB (Unemployment/Disability Benefits)			Other Pension or Disability		
Worker's Compensation			Loans, Gifts, Contributions		
Child/Spousal Support			Winnings (bingo, lottery, prizes, etc.)		
Strike Benefits			Other: (Explain)		
Native American per capita payments					

If "YES", complete below:

NAME	SOURCE	AMOUNT (BEFORE DEDUCTIONS, IF ANY) \$	WHEN	HOW OFTEN
NAME	SOURCE	AMOUNT (BEFORE DEDUCTIONS, IF ANY) \$	WHEN	HOW OFTEN

☐ Verif(s) on File
 Explain Anticip. Income

Exempt
☐ YES ☐ NO
 Exempt
☐ YES ☐ NO

15

A. Does anyone pay for care of a child or disabled adult, so they can go to work, training, school, or look for a job?☐ YES ☐ NO

If "YES", explain below

NAME OF PERSON WHO RECEIVES CARE CHECK (✓) ONE: <input type="checkbox"/> ADULT <input type="checkbox"/> CHILD	NAME OF PERSON WHO PAYS	NAME OF PERSON WHO GIVES CARE	HOW MUCH \$	HOW OFTEN
NAME OF PERSON WHO RECEIVES CARE CHECK (✓) ONE: <input type="checkbox"/> ADULT <input type="checkbox"/> CHILD	NAME OF PERSON WHO PAYS	NAME OF PERSON WHO GIVES CARE	HOW MUCH \$	HOW OFTEN

WHY CARE IS NEEDED:

B. Does anyone pay all or part of your child care costs?☐ YES ☐ NO

Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc.

If "YES", explain below

NAME OF CHILD	NAME OF PERSON WHO PAYS	MONTHLY AMOUNT PAID \$	WHEN
NAME OF PERSON WHO PAYS	NAME OF CHILD GETTING CHILD SUPPORT	AMOUNT PAID PER MONTH	COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO

Court order on file ☐ YES ☐ NO
 Amount ordered \$

Indicate type of child care program:
 Dept. Of Education, Block Grant, etc.

16

Does anyone in the home pay child support?☐ YES ☐ NO

If "YES", explain below

NAME OF PERSON WHO PAYS	NAME OF CHILD GETTING CHILD SUPPORT	AMOUNT PAID PER MONTH	COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF PERSON WHO PAYS	NAME OF CHILD GETTING CHILD SUPPORT	AMOUNT PAID PER MONTH	COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO

17 A. Does anyone own or is anyone buying real estate anywhere (in or outside the United States)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below. Include all real property owned, used, controlled, shared or held.						COUNTY USE ONLY				
TYPE (LAND, HOUSE, APARTMENT, ETC.)	ADDRESS OR LOCATION	USED AS: <input type="checkbox"/> HOME <input type="checkbox"/> RENTAL INCOME FROM RENTAL PER MONTH: \$	OWNER(S)	ESTIMATED VALUE	AMOUNT OWED	Home exempt <input type="checkbox"/> Yes <input type="checkbox"/> No Rental Exempt <input type="checkbox"/> Yes <input type="checkbox"/> No Other Real Property Market Value \$ _____ Amount Owed \$ _____ Net Value \$ _____				
TYPE (LAND, HOUSE, APARTMENT, ETC.)	ADDRESS OR LOCATION	USED AS: <input type="checkbox"/> HOME <input type="checkbox"/> RENTAL INCOME FROM RENTAL PER MONTH: \$	OWNER(S)	ESTIMATED VALUE	AMOUNT OWED					
B. Does anyone, including children, have any of the resources listed below? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below. Include all resources owned, used, controlled, shared or held jointly with or for another person(s). The county will figure if these resources count. Check (✓) YES or NO for each item. (Do not include the home you are living in, household goods, or personal items (books, clothes, etc.).)						<input type="checkbox"/> Resource Verified: Explain how:				
		YES	NO		YES				NO	
Cash or checks (on hand or elsewhere)				Notes, mortgages, deeds of trust, sales contracts (payable to you)						
Checking/Saving account/credit union accounts				Retirement Funds (if you are no longer working)						
Stocks, bonds, certificates of deposit, money market accounts, etc.				IRA or Keogh Plans, Employee Deferred Compensation						
Trust funds				Other (Explain)			Total Value = \$ _____			
Oil, mining, or mineral rights										
If "YES", complete below.										
TYPE OF RESOURCE	OWNER	CURRENT VALUE	AMOUNT OWED (IF ANY)	NAME AND ADDRESS OF BANK, ETC.	ACCOUNT NUMBER	<input checked="" type="checkbox"/> if exempt				
		\$	\$							
		\$	\$							
		\$	\$							
C. Does anyone get income from any of these resources, such as interest, dividends, etc.? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below.										
NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN							
		\$								
NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN							
		\$								
D. Does anyone own any cars, trucks, boats, trailers, vans, campers, motorcycles, mobile homes, houseboats, jet skis, snowmobiles, or other vehicles? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE THE FOLLOWING FOR EACH VEHICLE, EVEN IF NOT RUNNING. Look at your registration to get facts for each vehicle you own.						Vehicle value (Enter Date of blue book issue or other documentation) (1) Date: _____ \$ _____ (2) Date: _____ \$ _____ (3) Date: _____ \$ _____ <input type="checkbox"/> Leased vehicle: <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3)				
	Vehicle (1)	Vehicle (2)	Vehicle (3)							
OWNER OF VEHICLE										
NAME OF PERSON WHO USES VEHICLE										
YEAR/MAKE/MODEL										
LICENSE NUMBER										
ESTIMATED VALUE	\$	\$	\$							
BALANCE OWED	\$	\$	\$							
LICENSED? (✓) LEASED (✓)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No						
HOW DO YOU USE THIS VEHICLE? Check (✓) each item YES or NO	Yes	No	Yes	No	Yes	No	TOTAL RESOURCES \$ _____			
As a Home										
To go to work or training or for job search										
For work, self-support or self-employment										
Needed for disabled household member										
To get household's fuel or water										
COUNTY USE ONLY - VEHICLES						(C) Fair Market Values				
(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)	VEHICLE (1) <input type="checkbox"/> YES (Exclude) <input type="checkbox"/> NO Go to B		VEHICLE (2) <input type="checkbox"/> YES (Exclude) <input type="checkbox"/> NO Go to B		VEHICLE (3) <input type="checkbox"/> YES (Exclude) <input type="checkbox"/> NO Go to B		FMV			
							Minus \$ 4650	Minus \$ 4650	Minus \$ 4650	Minus \$ 4650
							Excess Value			
(B) 1. Is vehicle for home use? (Allow one vehicle only) OR 2. Is vehicle used for job search, employment or training? (63-501.523)	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to C Use Excess Value		<input type="checkbox"/> YES <input type="checkbox"/> NO Go to C Use Excess Value		<input type="checkbox"/> YES <input type="checkbox"/> NO Go to C Use Excess Value		FMV			
							Minus Encumbrance Equity Value			

- (18) Has anyone sold, spent, or given away any real or personal property in the last 3 months such as a house, land, cars, bank accounts, money from a legal or accident settlement, or anything else?** ☐ YES ☐ NO
If "YES", explain what and when:

COUNTY USE ONLY

- (19) A. Do you or anyone living with you have any housing costs?**

If "YES", complete below:

TYPE OF HOUSING COST	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	\$	\$	\$	
House (mortgage) payment	\$	\$	\$	
Property taxes (if not in house payment)	\$	\$	\$	
Insurance (if not in house payment)	\$	\$	\$	
Other (explain)	\$	\$	\$	

- B. Does anyone else pay all or part of these housing costs? Include a relative/friend not living in the home, any rental assistance programs such as HUD, Section 8, etc.** ☐ YES ☐ NO

If YES, complete below:

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH ONE PAYS	HOW OFTEN BILLED
		\$	
		\$	

Total housing verified?

☐ YES ☐ NO

Total housing \$ _____

Shared housing

☐ YES ☐ NO

- (20) A. Do you or anyone living with you have utility costs, which is not part of the rent paid?** ☐ YES ☐ NO

If Yes, complete below:

TYPE OF UTILITY COST	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBER PAYS	HOW OFTEN BILLED
Gas or other fuel	\$	\$	\$	
Electricity or other fuel	\$	\$	\$	
Is the gas or electricity or other fuel used to heat or cool your house?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Water	\$	\$	\$	
Sewage	\$	\$	\$	
Garbage or trash	\$	\$	\$	
Telephone (basic rate)	\$	\$	\$	
Installation of utilities	\$	\$	\$	
Other (explain)	\$	\$	\$	

- B. Does anyone else pay all or part of these utility costs? Include a relative/friend not living in the home, Low Energy Assistance, etc.** ☐ YES ☐ NO

If YES, complete below:

TYPE OF UTILITY COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		\$	

Utilities verified?

☐ YES ☐ NO

Client elects:

☐ Actual ☐ SUA

If actual,

Total utilities \$ _____

SUA prorated:

☐ YES ☐ NO

If YES, show computation.

- (21) You can authorize someone else in your household or someone outside your household to pick up your food stamps for you and to use them to buy your food. If you would like to authorize someone, complete below.**

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		()

☐ I.D. Issued

- (22) Have food stamps been stopped for anyone due to non-cooperation for any reason, including a quality control review, or because of work or training sanctions, or failure to meet the Able-Bodied Adult Without Dependents (ABAWD) work requirement? If YES, complete below:** ☐ YES ☐ NO

NAME	WHY	WHEN	HOW LONG?	WHAT COUNTY/STATE
------	-----	------	-----------	-------------------

- (23) Have food stamps been stopped for anyone for an Intentional Program Violation or Welfare Fraud?** ☐ YES ☐ NO

If YES, complete below:

NAME	WHY	WHEN	HOW LONG?	WHAT COUNTY/STATE
------	-----	------	-----------	-------------------

- (24) Is any member of the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or a parole or probation violation? If YES, complete below:** ☐ YES ☐ NO

NAME:

- (25) Has any member of your household committed and been convicted of a drug related felony for possession, use, or distribution of a controlled substance(s) after August 22, 1996? If YES, complete below:** ☐ YES ☐ NO

NAME OF PERSON CONVICTED	DATE OF CONVICTION	DATE COMMITTED
NAME OF PERSON CONVICTED	DATE OF CONVICTION	DATE COMMITTED

CERTIFICATION

- I understand the questions on this form.
- I understand that any facts I have given, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and employment agencies, etc.
- I understand the county will send information to the Immigration and Naturalization Service (INS) for verification of noncitizen status and to the Social Security Administration to check work quarters information, if I am a noncitizen.
- I understand the information the county gets from INS and/or Social Security may affect my eligibility for food stamps.
- I understand information, including benefit and income facts, that I have given on this form is subject to investigation and review by the county, state, and federal personnel, and that if I give wrong facts my food stamps may be denied or stopped.
- I understand the penalties, including the specific disqualification penalties for food stamps, for giving wrong or incomplete facts, failing to report facts or situations which may affect my eligibility or benefits for food stamps.
- I understand that the food stamp household, any adult member of the food stamp household (even if they move out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- I understand that my case may be selected for additional review to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- I understand that any member of my household who is avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction or in violation of their parole or probation cannot get food stamps.
- I understand that anyone who has committed and been convicted of a drug-related felony for possession, use or distribution of a controlled substance(s) since August 22, 1996, cannot get food stamps.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this statement of facts is true, correct, and complete.

SIGNATURE (ADULT HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE)	DATE
WITNESS, IF YOU SIGNED WITH AN "X", OR SIGNATURE OR INTERPRETER	DATE
ELIGIBILITY WORKER SIGNATURE	DATE

COUNTY USE ONLY

REGULATIONS MET? CHECK (✓) EACH ITEM	YES	NO	N/A	IF NO, NAME
Residency				
Citizen Status				
Noncitizen Status				
Sponsored Noncitizen				
SSN				
Resources-Within limits & Amount \$				
Work Registration/ABAWD				
Student Regs				
Categorically Eligible				
Gross Income Test Household Size Gross Monthly Income \$				
Gross Income Eligible				
Separate HH Income Test Household Size Gross Monthly Income \$				
Eligible for Separate HH Status				
Aged/Disabled DFA 285-C Given and Completed				
<input type="checkbox"/> INELIGIBLE (REASON)				
EW SIGNATURE		DATE		